



## Vermont EMS Today

June 1998

From the Director

# Sometimes It Really Does Work!

Many of you have heard my presentation at EMT courses about how difficult it is to provide prompt, highly sophisticated emergency medical care within the environment of Vermont. The overwhelming majority of our EMS providers operate in conjunction with fairly small, fairly rural squads that frequently cover large geographic areas with relatively low population densities.

One effect of these demographics is that most EMS providers in Vermont

have a low exposure to emergency patients. That fact is both good and bad. I'm glad that most of us live in communities where people aren't constantly requiring emergency care. On the other hand, when someone does need EMS, there is a fairly high likelihood that the responders providing emergency care didn't see a similar case the week before.

The realities of call volume and skill exposure in Vermont are one of the reasons we all need to commit as much time and energy as we do into continuing education and refresher training. If we are going to keep our skills honed and our knowledge at the cutting edge, we have to keep working at it. One way that many Vermont EMS providers do that is by attending the annual Vermont EMS conference.

I'm really happy about many parts of the EMS conference. It's a great opportunity for people from around the state to network. Participants are able to see some of the latest EMS equipment and programs. We've been fortunate in attracting some of the state's, region's and nation's best EMS presenters. All of this experience is packaged in a pleasant social setting where people can relax and share experiences with colleagues.



At the 1998 EMS conference, I had the pleasure of presenting a program called "Fascinomas" with Dr. Wayne Misselbeck, our State EMS Medical Advisor. Wayne had collected a series of interesting cases he had seen in the emergency department that had been brought in by EMS. The logic of the presentation was to select patients for

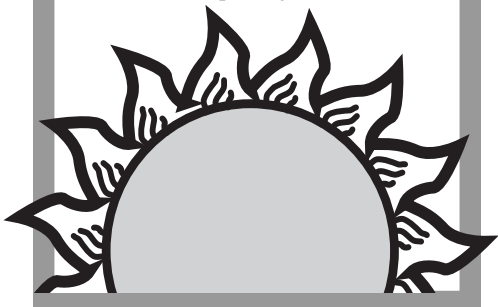
whom the presentation in the field was not entirely clear and to walk through the complexities of assessment and management in the hospital. In several of the cases, information that was obtained or could have been obtained in the field was important to the patient's course of treatment in the hospital.

My role in the presentation was to share tips and suggestions with the pre-hospital providers about how to use the information in real life field practice.

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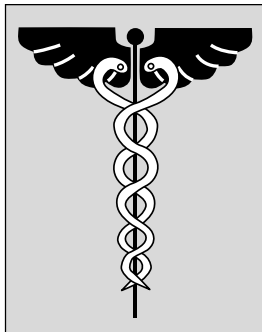
### Inside:

Medical Advisor .....	2
Infectious Disease .....	3
Training Update .....	4
Summer Days are Here Again .....	6
Special Project Update .....	7
New EMT-B Refresher Exam .....	8
Profile of a VT EMS Provider .....	10
Crash Data Reporting .....	11



# Public Access Defibrillation: Maybe we can do it, but should we?

As the American Heart Association, American Red Cross and some highly respected physicians begin their rallying cry to let the public have defibrillation, we who have some experience in this area should think concertedly and then speak to the issue.



Some of us have been around EMS for a while and have seen some pretty interesting "treatments" come and go. Wasn't it only a few years ago that many restaurants and cafeterias had prominently displayed for spectator sport such notable lifesaving devices as the "Choke Saver?" How could anyone argue that if a victim is choking someone ought to haul that hunk of matter out there? Can any of you recall seeing one of these recently? And for you fellow fossils, can anyone recall how often these were used by the general public and with

what success? History has some interesting lessons.

As we approach public access defibrillation, I take pause to consider many aspects. I know well that the undisputed treatment for V-fib is defib. There is little argument from me that the new semi-automatic defibrillators are simple,

accurate, dependable and getting cheaper. So, the obvious conclusion must be, put them everywhere? Maybe, but I have my doubts.

Speaking of simple, accurate, dependable and cheap, what about those fire extinguishers that we see everywhere? How often does the public use them and when they do, is it in the correct manner? Does it slow the notification of the fire department? Is it the next best expenditure of dollars?

Many of the same issues surface as we consider making defibrillators widely available. There isn't a one of us who wouldn't admit that we require frequent training in the use of these machines and CPR to do it well. Few of us would be impressed if the presence of the machine allowed a false sense of security concerning prehospital care or delayed EMS response as well wishers fumbled to use the machine without E911 notification.

While we all can agree that the cost, very much like computer sales, is decreasing to a point where consideration of having defibrillators more widely available is feasible, this is where I would expend my next several thousand dollars to improve the EMS system in my community.

Our statewide project on semi-automated defibrillation netted some interesting results. Even with median responses of eight minutes or less, only one-third of our patients in witnessed

arrest were in ventricular fibrillation. Of these there was a 10 percent survival to hospital discharge in good condition. Practically speaking, if there is approximately one cardiac arrest per thousand population per year, what is the likelihood of the machine ever being used or of saving a life? Life is precious; however we can realistically ask, "How can I expend the resource to benefit the maximal number of people most effectively?"

Needless to say, the equipment needs to be checked and serviced periodically to function. While many of the newer machines can perform a daily self check, there is still a need to have someone look at those results and see to it that expired pads are replaced, broken wires are repaired and dead batteries replaced.

While the final chapter has not yet been written, some recent literature questions the increase in numbers of defibrillators in systems that already have many elements of the "chain of survival" since no change in survival was found. There is little or no data concerning public use of defibrillators. The experience of use by family members for a family member patient who was at risk for sudden death has been variable, but generally poor. If folks have reluctance and difficulty defibrillating family members, how likely are they to defibrillate a stranger?

Whatever the eventual outcome of the decision to allow public access to defibrillation, I hope that we avail ourselves of the opportunity to learn and improve the chances for survival out-of-hospital. I will be very displeased if all we do is buy a more expensive MAST garment. I hope that each of you will give thoughtful consideration to this national debate and give valued input into the future of this great cause.

—Wayne J.A. Misselbeck, M.D.  
Medical Advisor

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## Vermont EMS Today

is published quarterly as a service for Vermont's emergency medical providers. Suggestions, comments and news items are always welcome. Write or call Leo J. Grenon, Vermont Dept. of Health, 108 Cherry Street, Box 70, Burlington, VT 05402. (802) 863-7310 or 1-800-244-0911 (in Vermont only). Email: VTEMS@VDH.STATE.VT.US

## Division of Health Protection

Larry Crist, *Director*

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Richard P. Gaun III, *Operations Coordinator*

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# What's Spreading in Infectious Disease

**L**ate last year the Occupational Safety and Health Administration (OSHA) proposed a rule on occupational exposure to tuberculosis (TB). This would replace OSHA's use of the general duty clause in requiring employers to protect their employees from TB. The proposed rule requires employers to take a number of actions, including educating employees about recognition and prevention of transmission of the disease, providing annual skin tests and requiring the use of certain devices to limit the spread of the disease. The proposed rule on occupational exposure to tuberculosis is in the Federal Register (62:54159-54309). It is also available on the web at [www.osha.gov](http://www.osha.gov) or from the Health Department's Office of Occupational and Radiological Health (865-7730). The reaction to the proposed rule was very strong and very vocal, so it is not

clear yet what changes might be made or when the rules would go into effect.

On May 15, the Centers for Disease Control and Prevention (CDC) published



"Public Health Service Guidelines for the Management of Health-Care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis." These guidelines describe the evaluation of a

potential exposure to HIV and the risks and benefits of postexposure treatment with the different drugs available today. Since the likelihood of a healthcare worker becoming HIV-positive after a needle stick from an HIV-positive person is only three in one thousand (0.3%), the decision whether to administer these toxic drugs is not a simple or easy one. The recommended medications are thought by experts to be the best prophylactic treatment but have not been proven to be effective in preventing seroconversion. They also have serious side effects. Since any use of these medications needs to be very soon after an exposure (a few hours at most) and supervised by someone familiar with them, a designated infection control officer should speak to a physician who is familiar with these drugs before an incident occurs.

—Mike O'Keefe

## From the Director— Sometimes It Really Does Work

CONTINUED FROM PAGE 1

Preparing for the presentation was a great learning experience for me. Wayne and I went over the cases in some detail and I learned several things about some complex patients.

One of the cases involved a patient who had recently changed medications. The take home message for EMS providers was to probe thoroughly about the medications a patient is taking. What has the patient recently started or stopped taking? Has the patient had a recent dosage change in any meds? Is the patient taking anything over the counter? None of these questions are "rocket science" to obtain, but certainly represent a higher level of assessment than just asking, "What medications do you take?"

A couple of weeks after the conference, I first responded to a call for an

elderly woman having heart palpitations. I arrived on the scene and began the assessment and care of a pleasant, conscious and alert female in her late 70's. She was awakened by a "fluttering" feeling in her chest, which seemed to correlate with an irregular radial pulse. She was having no chest pain or difficulty breathing. She did have several past medical problems including a history of arrhythmias and she was taking a number of medications.

The ambulance was still ten or more minutes away and the patient was resting comfortably on oxygen, so I continued with more detailed questioning. "Have you changed any of your medications recently?" The patient replied; "Well yes, my doctor told me to taper down the dosage of my anti-arrhythmic drug in preparation for some elective surgery." Bingo, the presentation suddenly fit. It also appeared to me that the patient rested a little easier as the light bulb came on as to why she was likely having this problem.

I mentioned this patient to Dr. Misselbeck a few days later and commented how easy it would have been to miss identifying the problem if we hadn't done the fascinos presentation. His conclusion was that I probably saved the ED staff a fair amount of time retracing the patient's detailed medical history to come to the same conclusion.

Did any of this save the patient's life? Absolutely not. Did it make the patient feel a little less anxious, help the ED staff and speed the patient's care in the system? Quite probably. As satisfying as it was to make a little contribution to this particular patient, it also reinforced to me the importance of continuing education. Rarely do we get such a clear opportunity to apply a recently learned element of knowledge or skill. I suspect that we use lots of little tools that we may not even remember learning. Sometimes it really does work and that moment of success makes all the hours of preparation and practice worthwhile.

—Dan Manz, Director



## Transition to EMT-B

Getting from point A to point B, or from EMT-A to EMT-B, is proceeding very well. As of April 1, more than 1600 EMTs have taken the EMT-B course or transition course. Since we have approximately 1900 EMTs in Vermont, this means more than 80 percent of our EMTs have made the transition and are able to use the new interventions in the 1994 EMT-B curriculum.

Students are performing extremely well on the written exam. Just over 97 percent pass it in the first attempt. The average score is 88.4 percent with a standard deviation of approximately 6 percent.

Credit for the success of this program goes to the 51 instructor-coordinators who have conducted 75 transition courses since January 1996 (see the table on page 5 for specific figures).

## EMT-B Refresher Exam

For the last few months, Vermont EMS has been pilot testing a new EMT-B refresher exam. Preliminary results have been quite good. After the results of the practical exam and the performance of the pilot questions have been evaluated, the exam will be revised so that it is ready for use on July 1. See the article on this topic on page 8.

## National Registry of EMTs

Vermont's EMT-B students continue to perform well on the National Registry exam, with a pass rate higher than most states. Approximately 82 percent of our students pass the written exam on the first attempt. Although becoming a Nationally Registered EMT is entirely voluntary, most students are taking advantage of this opportunity.

A number of recertifying EMTs are also becoming Nationally Registered. Although a person who is due to take the Vermont recertification exam can substitute the National Registry written exam, we do not recommend it. More people fail the Registry exam than fail the Vermont recert exam on the first try (18% vs. 3%). This means someone who takes the Registry exam puts his or her Vermont certification at risk. A better approach is to pass the Vermont recert exam and then take the Registry written exam. The Registry will recognize the applicant's performance on the practical exam for 12 months. This should give almost everyone the chance to take the Registry written exam with an EMT-B class without risking anyone's Vermont EMT certification.

## Regaining Expired EMT Certification

One of the many changes in the revised EMS Rules which went into effect in March 1997 describes how a former EMT can regain certification. If the EMT certification expired less than a year ago, the person need only fulfill the same testing and continuing education (CE) requirements of a recertifying EMT. There is no longer any need for additional CE to cover the time since the certification expired. Another change, though, is that the new EMT card will expire two years after the last one expired. This means that if someone waits eleven and a half months after expiration to renew the EMT card, the new card will be good for only twelve and a half more months.

If the EMT certification expired more than a year ago, but less than three years ago, the person must complete an EMT-B refresher course and the refresher exam. The CE option is not available to former EMTs whose certification expired more than a year ago.

If more than three years have passed since the person's EMT card expired, the person will need to complete another EMT-B course.

The three year limit is fairly generous when one considers that such a person might not have had any training or education for almost five years (two

### Number of Providers Trained in 1994 EMT-B Curriculum as of 4/1/98

	Fiscal 1996	Fiscal 1997	Fiscal 1998	Total	Grand Total
EMTs who have completed 1994 EMT-B course	37	236	167	440	
EMTs who have completed EMT-B transition course	173	729	263	1165	1605
Number of EMT-B courses using 1994 curriculum	2	15	11	28	
Number of transition courses	10	49	16	75	

years certified plus just under three years uncertified).

Reinstatement of expired EMT-Intermediate certification is almost the same as before. If less than six months have passed since the EMT-I certification expired, the person must have (or regain) current EMT-B certification, fulfill the usual CE requirements and get the support of the district medical advisor. The difference is that a person's EMT-I certification is always timed to expire at the same time as the person's EMT-B certification.

If more than six months have passed since the EMT-I certification expired, the person must complete another EMT-I course unless the district board and the district medical advisor petition for some other course of action and the Department of Health grants the petition.

### Instructor/Coordinator Course

Late this summer or early fall, Vermont EMS will sponsor an EMS instructor-coordinator (IC) course in Burlington. The course is open to EMTs who are recommended by a district board. Applications will be sent to district chairs and trainers, not services or individuals, because space is limited and each applicant must have the support of a district board. Preference will be given to applicants who have demonstrated an interest in and commitment to teaching. Once the dates for the course are confirmed and the fee is determined, more information will be sent to district officials.

— Mike O'Keefe  
State Training Coordinator

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## MARK YOUR CALENDAR!

## 1999 EMS

# Conference

## APRIL 9, 10, & 11, 1999





# Summer Days are Here Again!

Now that our children are out of school, there will be more activity among the young people of our communities. It is the time of the year when we have to gear up as pre-hospital providers and make members of our communities aware of what they can do to help prevent injuries to all. Here are just a few safety tips. I know you have heard them before, but they are especially appropriate at this time of year.

☼ Be aware of unusual weather changes.

For example, if tomorrow is going to be 90°, wear light clothing and drink plenty of liquid if performing manual labor or exercising. Do not leave the young ones out too long in the direct sunlight. Have them take breaks inside or play in the shade, and drink fluids. Remember, they don't know when they are getting severe sunburn or heat-related life-threatening illnesses.

☼ Think about safety at cook-outs. When adults are in and out of the house to get food or to visit, the little ones can get lost in the shuffle. Always keep in mind that a child can move very quickly to the hot coals in the barbecue pit and become severely burned. And, please make sure when the cook-out is over that the hot coals are completely out to avoid further injury.

☼ ALWAYS have an adult supervise children when near swimming pools, rivers, lakes, etc. Leaving a child unsupervised, even for a minute, in these situations puts them at great risk of injury or even death.

☼ We have all probably assisted with putting on a bicycle helmet safety program in our community. Let's refresh peoples' memories on the importance of those helmets in preventing serious

injuries. We must not forget the importance of the little ones wearing their helmets when riding the tricycle. We should be training our children at that age, forming good prevention habits. Also important to remember is that at ages three, four and five, a child's head size changes considerably, requiring a different helmet size from year to year. A small sized helmet hurts and will come off the child's head as soon as an opportunity presents itself. So check those sizes.

☼ Skateboarders should wear helmets and pads for the knees and elbows.

☼ Be most careful of animals of all kinds, domestic and wild. You should not approach any animal that is not the family pet, unless the animal is under direct supervision of its owner and they say that it is safe to approach the animal. DO NOT ever approach wild or stray animals (especially in today's unsettling times of rabies). If your family pet is acting strange or aggressive, try to contain the pet from human contact and call your local health officer or your local veterinarian. Any fur bearing animals can be carriers of rabies, including bats.

☼ Don't leave dangerous fluids like gasoline, paints, pesticides, etc. where they are accessible to a child.

☼ Do not mow the lawn while children are in the area. When you mow, debris is thrown by the machine and if a child is in the line of fire, serious injury may occur, especially to the eyes of the youngster. When you are done with the lawnmower, the engine will remain very hot for a long time, so make sure that it is covered and out of reach of children. Touching the hot engine will result in serious burns.

☼ Our children are home more now that school is out. They will explore more because they have more time on their

hands. So what you think was in a safe place before may not be so safe now. They will explore the house, barn, garage, automobiles, etc. Medicines, matches, lighters, and loaded guns are some of the items we should re-assess the location of. ALWAYS keep ammunition in a different location than the gun.

☼ Always wear shoes. Plenty of foot injuries result from people not wearing shoes in the summertime. Also, the black pavement and hot cement sidewalks can be painful on a young child's feet. Survey the area where children play and remove all dangerous debris in case they take off their shoes. (They will.)

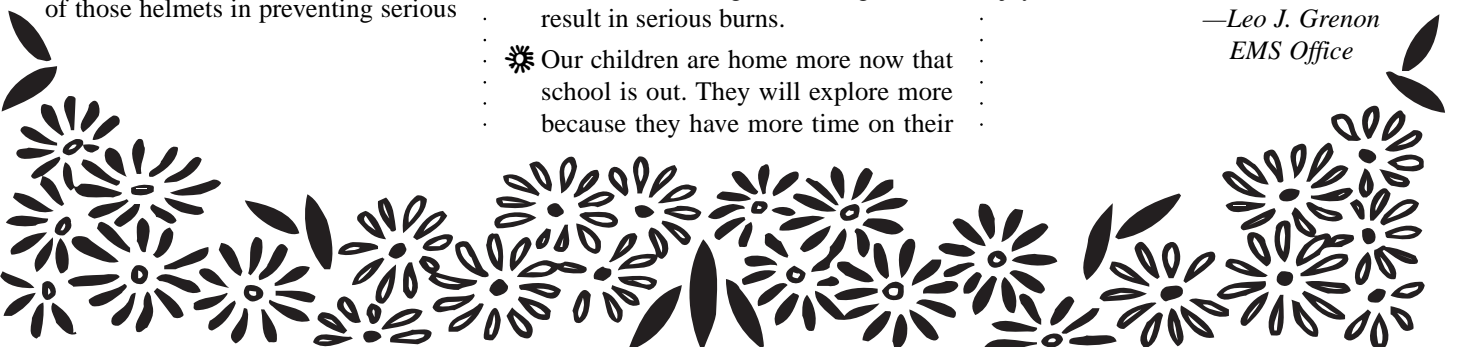
☼ Pay special attention when moving your car. Children will play in the strangest places, like on the back side of a car. So, before you move your car, make sure no one is near it and watch out for those tricycles and bicycles that come out of nowhere.

☼ Always wear your seatbelts and insist that anyone riding with you do the same. There is no excuse good enough for not wearing a seat belt or using the proper safety seat for a youngster, especially when one considers the possible consequences.

☼ When boating, have everyone wear a proper flotation device, know the limitations of your boat and do not overload it.

These are only a few injury prevention reminders we can share with our neighbors and friends. Let's all watch out for each other, especially the little ones. We at the EMS Office hope you have a safe and enjoyable summer.

—Leo J. Grenon  
EMS Office



# SPECIAL PROJECT UPDATE



## Pediatric Office Resuscitation Project

In May, the Pediatric Office Resuscitation Project was concluded. Thirty-eight of the 40 pediatric practices in Vermont participated. Over 300 health care providers participated in the training program. Congratulations to Barry Heath, MD, and Jean Coffey, RN, for a job well done.

## EMSC National Congress

In March, the first National EMSC Congress was held in Washington, DC. Vermont was well represented with four individuals from the Green Mountain State: Dennis Vane, MD, of the University of Vermont College of Medicine, Brian Patno and Jan Slyk of Rescue Inc. in Brattleboro and Patrick Malone from the Department of Health. The group learned a great deal and has several ideas for future EMSC projects.

One of the most significant events at the Congress was the

presentation of awards by the federal EMSC Program. Janet Houston of the New Hampshire EMSC project was named the 1998 EMSC Project Director of the Year. Janet's great work touches quite a few members of the Vermont EMS system. Congratulations to Janet!



## Telemedicine Conference

The Initiative for Rural Emergency Medical Services at the University of Vermont is facilitating the planning and delivery of a continuing medical education conference in conjunction with the Emergency Medical Services for Children Projects in each of the six New England states. The conference will focus on a variety of pediatric emergency care issues. One unique aspect of the program will be the delivery of the conference using telemedicine technology. Individuals will be able to participate in the program at six separate sites, one in each of the New England states. The use of telemedicine technology will result in increased participation and a reduction in the time and expense required of individuals to participate. Vermonters can attend the program at Fletcher Allen Health Care in Burlington or the Dartmouth Hitchcock Medical Center in Lebanon.

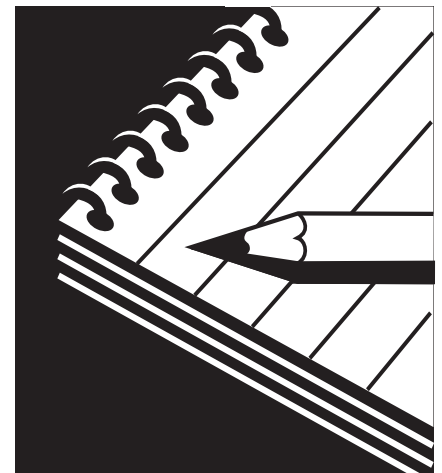
The conference will open with a presentation by Pat O'Malley, MD, on *Emergency Medical Services for Children: A National Perspective*. Dr. O'Malley is on the advisory board of the

National EMSC Resource Center and the medical advisor of the Massachusetts EMSC project. Nadine Levice, MD, of Johns Hopkins University will give a presentation on *Pediatric Restraint for Ambulance Transport: A Need for Dynamic Standards*, addressing the issue of how to safely transport children in ambulances. The endnote presentation, *Injury Prevention*, will be made by Barbara Barlow, MD, of Columbia University.

The following presentations will also be delivered: *Pediatric Airway Management* (Jean Proehl, RN, Dartmouth-Hitchcock Medical Center), *Pediatric Airway Management* (Craig Bonnani, MD, Connecticut Children's Medical Center), *Kids vs. Cars* (Dennis Vane, MD, UVM College of Medicine/Fletcher Allen Health Care), *The Pediatric Office Resuscitation Project* (Barry Heath, MD, UVM College of Medicine/Fletcher Allen Health Care), and *Emergency Care of the Special Needs Child* (Gary Klienman, NREMT-P, Rhode Island EMSC).

The conference will be held on Friday, October 2, 1998 from noon until 5:00 p.m. The cost is \$40.00. Brochures and registration information will be mailed to all services in early July.

—Patrick T. Malone  
Special Project Coordinator



# The New EMT-B Refresher Exam

One of the many changes associated with the 1997 revision of the EMS Rules is a new refresher examination for EMTs. Vermont EMS is pilot testing this new exam until June 30 so that it will be ready to use on July 1. Vermont EMS sent a memo about these changes to all service training officers in April. To help providers understand the differences between the old and new exams, we are providing that information here in a question and answer format.

## What is the written exam like?

The EMT-B refresher exam consists of 120 multiple choice questions based on the 1994 EMT-B refresher curriculum. The exam is *not* based on any particular text. The passing score is 70 percent. There is a time limit of two hours to take the exam. The questions, like the refresher curriculum, are field-oriented and concentrate on EMT-B tasks more than definitions and abstract information. The exam will be scored at the EMS office.

The refresher curriculum is available free of charge on the internet at the National Highway Traffic Safety Administration's web site ([www.nhtsa.dot.gov/people/injury/ems](http://www.nhtsa.dot.gov/people/injury/ems)). If you would like a copy of the curriculum but do not have access to the web, send a blank formatted 1.44 MB disk to the EMS office. We will copy the curriculum onto the disk and return it to you. The disk must be high density (not double density).

## What is the practical exam like?

The practical exam or skill verification consists of three stations: Trauma Assessment and Management, Medical Assessment and Management, and Cardiac Arrest Management. Station 1,

Trauma Assessment and Management, resembles the traditional trauma assessment station, but the candidate is now expected to treat the injuries found. This means that instead of describing the treatment (as done in the past), the candidate will actually perform the treatment. This will include controlling bleeding, splinting an injured extremity and immobilizing the patient on a backboard.

An assistant will be available at the station to assist the candidate, but will not initiate any treatment. In other words, the candidate will have to tell the assistant what to do, for example, "Fasten that strap across the patient's chest, please." The candidate will not need to tell the assistant how to do something an EMT-B is trained to do, like fastening a backboard strap. This is a single person station and the candidate will have 15 minutes to complete it.

At Station 2, Medical Assessment and Management, the candidate will assess and treat a patient with a medical complaint. This will include administering high concentration oxygen and assisting the patient with one of his or her own medications. There will not be an assistant at this station. This is a single person station and the candidate will have 10 minutes to complete it.

Station 3, Cardiac Arrest Management, combines use of an automated defibrillator with airway management, ventilation with oxygen and CPR. This is a two person station. One candidate will operate the AED and use the airway adjuncts and the other candidate will do CPR. The evaluator will then read a new scenario and the two candidates will switch roles. The candidates will have 10 minutes to complete the station.

In April Vermont EMS sent every service training officer, district chair,

district training coordinator and EMT-B instructor-coordinator a copy of the performance criteria for the refresher practical exam.

## How is performance on the practical scored?

All of the performance criteria for the refresher exam were taken from the performance criteria for the old recert exam and the new EMT-B exam. A few of the items have been edited, but there is no new content. An EMT who has completed either a transition course or a 1994 curriculum EMT-B course should find the criteria very familiar.

There are several significant differences between how the old and new exams are scored.

The traditional method of assigning zero, one or two points to each step has been changed to a system where each step is rated "insufficient," "marginal" or "adequate or better." The presence of *either* any items scored "insufficient" *or* two or more items scored "marginal" requires remediation and the repetition of the station. In other words, a candidate passes if he or she gets all items scored "adequate or better" or if he or she gets no more than one item scored "marginal."

Any candidate who gets less than a passing performance will receive the opportunity **that day at that exam site** to practice the skill or skills and repeat the station. Since everyone going through these stations has passed at least one EMT practical exam previously (some many times) and has been active with a licensed service, the need to brush up on these skills should be uncommon. We anticipate the vast majority of recertifying EMTs will move through the three stations relatively quickly since



they have the necessary skills and experience to perform well. A few people will need to review their skills and will be able to perform adequately when they repeat the station that day. Rarely, a recertifying EMT may need more help than can be provided at the exam site and may need to brush up on the necessary skills with an instructor-coordinator or a training officer before repeating the station at a later time.

## Which exam does a recertifying EMT take?

Until June 30, 1998, this will depend on which of these three categories an EMT falls into.

1. *An EMT who took an EMT-B course that used the 1994 curriculum*

This person must take the new refresher exam.

2. *An EMT who has not yet taken an EMT-B transition course*

This person must take the old recert exam.

3. *An EMT who has taken an EMT-B transition course*

Until June 30, this person can choose between the old recert exam and the new refresher exam.

Each district decided this spring whether to conduct the old or the new exam (or both). Almost all districts chose to provide the new refresher exam.

Anyone due for recert testing should pay careful attention to the exam schedule that the EMS office mails with the exam registration form.

Beginning July 1, 1998, the new refresher exam will be the only recertification exam available. This means that any EMT due for recertification testing after July 1 will need to have taken an EMT-B transition course before taking the exam. For example: An EMT's certification expires December 31, 1998.

If a recert exam is available in December, the EMT has until then to take a transition course. If the recert exam he will take is in October, he must take the transition course before then.

Keep in mind that an EMT can recertify up to a year early without changing the expiration date on his or her EMT card. For example, someone who is due for recert testing in May 1999 can recertify 11 months early in June 1998 and get a new card that expires two years from the old one: May 2001.

## What is the schedule for implementation of this exam?

The refresher exam will be the only recertification exam available as of July 1, 1998. If an EMT needs more time to find a transition course, the person can request an extension of EMT certification for six months. **Extensions will not be renewed.**

More than 1100 EMTs have taken one of the more than 75 transition courses offered since January 1996. More than 50 people are qualified to coordinate transition courses in Vermont. To find out who is qualified, contact a district training coordinator, EMT instructor-coordinator or the EMS office.

## What is a refresher course and how does it relate to recertification?

An EMT-B refresher course is based on a national standard curriculum and includes 24 hours of instruction covering the 1994 EMT-B curriculum. Sixteen of the hours are in particular areas such as airway management and patient assessment (see the table). Eight of the hours are elective and may include anything in the 1994 EMT-B curriculum. This would include, for example, splinting, legal aspects or multiple casualty incidents. It

would not, however, include self-contained breathing apparatus, dive rescue or CPR instructor courses since these are not in the EMT-B curriculum.

The Vermont EMT continuing education form was revised in 1997 to reflect the requirement that a recertifying EMT must either take a refresher course or continuing education that meets the content and objectives of a refresher course.

## What are the risks and benefits of taking the new refresher exam?

The EMS Office is committed to making sure no recertifying EMT is harmed because of the pilot exam. Safeguards have been put into place to protect EMTs at the same time that the public is protected from incompetent practitioners.

The questions on the written exam will be evaluated and questions that perform poorly will not be counted. Candidates who need to repeat any practical stations will have ample opportunity for remediation, coaching and practice. The practical stations will also be evaluated and modified as appropriate.

With the change from one year certification and three year testing to two year certification and testing, Vermont EMTs have seen many changes recently. By the end of next year, the transition to this new system should be almost complete and this confusing time should be over. In the meantime, if you have any questions or comments, please feel free to call the EMS office.

— Mike O'Keefe

SEE CHART ON BACK PAGE

# Profile of a Vermont EMS Provider

## *An Interview with Linda Atherton*

BY TINA WOOD

### ABOUT THIS COLUMN

This column is designed to introduce Vermont EMS providers to others around the state. It's a chance to glean a look at the more personal side of who our responders are, the challenges they face, and the rewards they gain by being a provider. I hope you find it helpful in getting to know others and becoming more in tune with what is going on in EMS districts around the state.

Interviewees are picked at random. First, a district is selected, then it is narrowed down to a service, then the squad leader is approached and asked to submit the name of an individual to be interviewed. I find this to be the most fair way to choose who to interview.

Name:	Linda Atherton
Service:	Newport Ambulance Service, Inc.
Birth Place:	Lancaster, NH
Age:	45 years
Certification Level:	EMT-Basic
Years in EMS:	10 years

### BACKGROUND

Linda was born in Lancaster, New Hampshire, but was raised in Newport, Vermont. She graduated from North Country Union High School. After graduation, she began working in a local nursing home as a Licensed Nurses Aide. After working for 18 years in this capacity, she began work for Northeast Kingdom Mental Health (N.K.M.H.). She worked in a group home as a residential counselor with five mentally handicapped adults. Linda found this work to be very challenging and rewarding. After eight years working for N.K.M.H., the group home was closed. She still does respite for clients when she can.

Linda now works part time for the Newport Center Town School as a Licensed Nurses Aide. She loves working with the children. She also works part-time (evenings) at Columbia Forrest Products in Newport.

Linda is married and has one son.

Her husband has been very supportive of her volunteering for the Newport Ambulance Service, even with being awakened in the middle of the night. She has been with the service for about 10 years, one year as an ECA and nine years at the EMT level. She has also been a C.P.R. instructor for about one and one-half years.

Linda also serves as a volunteer in the Big Sister Program. She has been a "Big Sister" to a young girl for two years, and this has been very exciting for her. They like to spend time at her camp near Holland Pond, and enjoy swimming and fishing as well.

### *What do you enjoy most about being an EMS provider?*

"I also wanted to be a nurse, but didn't have the time and money to go to school. This is a very good way to be near people and help them."

### *How long do you plan on being in EMS?*

"This was going to be my last year in EMS, but our Coordinator (Mike) wouldn't leave me alone. So I guess I am going to retest this year."

### *What do you consider the most stressful part of being in EMS?*

"Trying to find time to keep active with the squad."

### *What made you want to become a provider?*

"I always wanted to help people, and I had a friend who was a former member who kept talking to me about joining the squad, so I did, and have enjoyed this very much."

### *What is your most memorable call?*

"The day I saved a lady from choking on a hot dog. I was working in the nursing home at the time when they told me to go to the dining room STAT.



*Linda and Larry Atherton*

"A lady had taken too big of a bite of her hot dog and couldn't breathe. She went unconscious after a while and then I lowered her to the floor and started abdominal thrusts. I don't know how long I was doing this. Just before the ambulance squad arrived I dislodged the hot dog. Wow! What a feeling."

*—My thanks to Linda for participating in this interview!*

*Tina Wood*

#### FACTS ABOUT NEWPORT AMBULANCE

ECA: ..... 7  
EMT-Basic: ..... 15  
EMT-I: ..... 11  
Call Volume 1997: ..... 811

#### ABOUT EMS DISTRICT #2

Number of Certified Personnel: 132  
ECA: ..... 50  
EMT-Basic: ..... 45  
EMT-I: ..... 37  
Call Volume 1997: ... 2,697

HOSPITAL: North Country Hospital in Newport.

There are 10 licensed services in District 2: 9 ambulance & 1 first responder. Only 2 out of 10 services have paid and volunteer personnel.

# Crash Data Reporting for the National Fatal Analysis Reporting System and the Vermont Crash Database

## Governor's Highway Safety Program

**D**o you know how the information you report from motor vehicle crash scenes is used?

Do you know where information about drunk driving, dangerous roadways and seat belt use is gathered? Have you ever heard of FARS?

The State of Vermont participates in the national data collection program for fatal traffic crashes, known as the Fatal Analysis Reporting System (FARS).

Vermont also maintains a crash data file for all police reported crashes. The United States Department of Transportation (USDOT), Agency of Transportation, Department of Public Safety and Department of Motor Vehicles all use crash data and FARS data to obtain an overall measure of highway safety, to help identify traffic safety problems, to suggest solutions and to evaluate the effectiveness of vehicle safety standards and highway safety programs. Data is confidential and used for statistical purposes only.

EMS personnel can make a valuable contribution to the FARS and Vermont crash information databases. EMS agencies often arrive at and observe the crash scene prior to the arrival of a police



officer. For that reason, important information that even police may not have, such as restraint use, ejection and extrication, can be gathered and provided by the attending squad members. Please assist the investigating officer to fill in the blanks on the Police Accident Report. Complete data makes safety efforts more reliable and effective.

Periodically, the Governor's Highway Safety Program sends a letter to your agency requesting information on fatal crash victims to whom your agency has provided care or transport. These forms provide valuable information to the FARS analyst and are necessary to complete information about fatal crashes for the National Highway Traffic Safety Administration.

The information you have furnished in the past has helped to identify problems with children and airbags, teenage drinking and driving and many other important issues to make Vermont roadways safer. Because of your help, we

have been able to provide high quality data to the national FARS database. We hope we can rely on your continued cooperation and contribution to this important program and for your support in helping the police fully and accurately complete Vermont accident reports.

If you have any questions about the FARS program, please call Michele Laberge at 244-1317.

—Submitted by Jeannie Johnson,  
Director  
GHSP Department of Public Safety  
State of Vermont



### Number of people holding Vermont EMS certification as of 12/31/97:

ECA		1068
EMT-Basic	(does not include advanced levels)	1121
EMT-I		749
EMT-P		43
Total EMTs at all levels:		1,913

## EMT-B Refresher Curriculum Topics and Hours

Division	Material to be covered	Min Hours
Preparatory	Scene safety, Quality improvement, Health and safety (lifting, carrying, stress management), Medical-Legal	1
Airway	Opening the airway, Suctioning, Artificial ventilation, Airway adjuncts, Oxygen	2
Patient Assessment	Scene size-up, Initial assessment, Focused history and physical examination, Detailed physical exam, Ongoing assessment, Verbal and interpersonal communication, Documentation	3
Medical/Behavioral	General pharmacology, Breathing difficulty, Cardiac emergencies, Altered mental status (including diabetes), Allergic reactions, Poisoning and overdose, Behavioral emergencies	4
Trauma	Shock, Open chest wounds, Open abdominal injuries, Amputations, Burns, Bone and joint injuries, Head and spine injuries, Rapid extrication	4
OB, Infants & Children	Normal delivery, Abnormal deliveries, Medical problems in infants and children, Trauma in children	2
Elective	Topics from EMT-B curriculum	8

## Vermont Emergency Medical Services

108 Cherry Street  
P.O. Box 70  
Burlington, VT  
05402

802-863-7310  
1-800-244-0911  
(within Vermont)